Minutes
DPHHS Rates Commission
May 17, 2006
Capitol Room 152
Helena, Montana

Attendees: Diana Tavary – Vice Chair, Wayne Hershey, Mary Jean Golden, Frieda Houser, Barb Varnum, Representative Christine Kaufmann – Chair, Senator Dan Weinberg, Lois Steinbeck, Bob Andersen, Janet Whitmoyer, James Corrigan, Kathy Brophy, Gail Briese-Zimmer

Absent members: Representative Penny Morgan, Senator John Cobb, Bob Olsen

Guests: Jeffrey Harrison – OPCA, Duane Preshinger – OPCA, Paula Block – MPCA, Mary McCue – MT Dental Association, Sami Butler – Intermountain Children's Home, Jani McCall – MCIPA, Jim Fitzgerald – Intermountain Children's Home, Mary Dalton – HRD, Denise Brunett – HRD, Paula Block, Primary Care Association

Welcome: meeting started at 1:03 pm
Representative Christine Kaufmann – Chair:
Commission was welcomed and thanked for taking time to make this a priority.

Approval of Minutes:
Commission Members:
Lois moved to approve the minutes, Wayne seconded. Motion was brought to a vote and minutes were approved with no opposition.

Importance of Commission:
Jim Fitzgerald – Intermountain Children's Home Executive Director:

Jim gave a brief overview of what Intermountain Children's Home does. He stated that they have worked very hard for a long time to invest a lot in prevention and intervention with children and families and working in a partnering fashion to build up the system of care. He stated a couple of the main principles had to do with the difficulty of being a provider and making it.

Jim stated that if you are in Human Services the government doesn't guarantee a prevailing union wage for you workers. Most providers working on a Medicaid reimbursement is about 80 cents on the dollar and the rest is required to have a fund raiser to make ends meet. The real difficulty there is that we have licensure contracts, administrative rules, etc that set criteria for providers to perform under that the rates do not support but they are held liable for compliance without funding to comply.
Jim stated that his personal driver was he believes that providers do need to be held accountable to produce an outcome for the patients. He states that it is very difficult to hold a provider truly accountable when they are not truly being paid a fee that allows them to comply with contracts licensure and administrative rules. We have this

accountability slip there and kind of that wink, wink that goes on. He states that the department and providers know that they are not really paid enough to comply let alone produce an outcome.

Jim feels that one real important contribution the commission can make is that providers being held accountable for the outcome that they are being paid to provide and comply with all the legislation, administrative rules, licensure and contracts that they have to do. Another is that the bureaucrats are to often put in a difficult position of having to determine rates not based on what it takes to provide the service but on the budget. They are in the process of having to set the rate and have a budget.
Jim feels that it will take a while for the commission to mature and become what it will. He states that he has a lot of hope for it and that it will make a real important contribution.

Jani McCall – Montana Children's Initiative Provider Association:

Jani stated that the MCIPA has eighteen providers across Montana who provides children's mental health, child welfare, and juvenile justice services. She stated that she feels legislation was very wise in passing this legislation and is really long overdue. The inequity in community services in the State of Montana for public community services has been very desperate for a long period of time. She gave a brief history or her experience over the past 29 years.

Jani stated that we have never had any sort of protocol that really looked at how rates have been provided. She feels that in the last two legislative sessions there has been a real awareness coming that this problem exist and people are beginning to acknowledge it. She feels that this commission has a huge challenge but a huge opportunity to make a difference on how people are served in the State of Montana. She states that the reality is that it all comes down to the people that we serve.

Jani stated that the first thing she feels the commission needs to do is become grounded in the history of what has happened so far, how the system is currently set up, and how services are currently provided and paid for. She thinks that the grid that has been worked on is a basis and begins to give people some of that knowledge and a quick comparison. She read a piece of the legislation that stated what the commission was created for.

Jani feels that this is a big mission and a big task but that it is doable. She states that this is the right place to start. She feels that there is a tremendous difference on how rates have been determined. There has never been a comprehensive sort of look at how we do this. She feels that when the Medicaid redesign was put together part of their role was to look at rate methodology. She feels that SLTC has done well and that the commission should maybe look at what they have done well and try to replicate those in different areas. She feels that the cost of care really needs to be determined and that is something that the Medicaid redesign is doing.

Jani feels that this group is on the right track and it is a good group of candidates. She states that she hopes that this group does not get bogged down in just getting reports.

Questions and Comments:

The question of who are the 18 groups and where are they was brought up by a commission member.
MCIPA represents providers from all over the state. Jani gave a list of some of those providers.

Comment about the wink, wink and lack of accountability between the department and providers concerned some of the members.

> Jim believes that the people in the department clearly know that there are not funds to fully comply with licensure and contracting administrative rules and that they do not hold providers accountable because they know that it is inequitable. He believes that there are efforts of accountability but there is clear knowledge on both sides of the fence that this is not a system that the light could be turned on.

What if there was a hypothetical law in place that said with every contract between the state and a provider where there would have to be some specification of what isn't happening that should be happening?

> Jim states that there is no real contract. Something is signed but there is no discussion or compromise. He believes that we are working very successfully to sit down and talk about what is in the contract and about administrative rules and trying to get some modifications.
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> Jani states that part of the problem is that even if there is a section in the contract that would say that, there is no one to oversee or monitor that except within the division. There is not continuity in the system and that is part of the vision of this group.

If there was a law in the contracts what would be the result of that or how would it change the system?

> Jim feels that the gap between what a provider can really provide and what they are being asked to provide. He feels the losers would be the client.

What can the commission do about it?

> Jim feels that a standardized methodology, a way of looking at services that have to be provided, a way of evaluating or measuring the cost of providing those service and coming up with a protocol or methodology that gets employed across all service levels. An objective rate commission that is not connected to the department, the providers, etc and comes up with that protocol across time would make a great contribution to the process.

It was brought up that there are two ways to go about doing the business on this rate commission. One is to learn about each individual rate and the other is to look at how ideally we would like to establish rates and then see how far away we are from the ideal. One thing the commission could do in time for the next session is try to get some of the standardized protocols that you might like to look at identified. One thing that needs to be done is to find out the cost of providing services.

It was stated that if we are looking at like systems it is easier to try to think about a rate methodology. Looking at physician services and those things that are covered under state plan Medicaid it would be hard to establish a methodology that could go across all services and all systems.

It was proposed that the commission add Jim and Jani to the commission as a technical advisor with no voting rights. A member stated out that they would bring some good ideas and bring in some more focus. It was also stated that there could be other people that could fall into the same category and we could end up with a large group of people that want to be involved on a regular basis. The commission could get caught up in the information that was just heard and so there are a lot of people that are just as invested and as knowledgeable as Jim and Jani. It was also brought up that the commission should try to add people to represent the eastern part of Montana.

Senator Weinberg made a motion to create three additional seats at the table for the chair person and the department to work together and fill with appropriate people for non-voting members. Mary Jean seconded. The motion was called to vote and was passed with no opposition.

A member asked what rules and regulations there are and if the commission could find out or get an idea of what there are.

It was stated that if we needed to know that the commission would be getting into something very large, volumes. What can be done is ask the department's legal staff if there are any rules and regulations that preclude the commission doing anything.

Dental Discussion Continued:

- **DPHHS Overview of Rates:**
  Duane Preshinger – OPCA Senior Medicaid Policy Manager:

  Duane gave a basic overview of his handout. He reiterated what was presented at the last meeting. He stated that the modifier EP stands for EPSDT. He stated that if anyone wanted to see the total fee schedule or dental provider he would be happy to print that out.

  Questions and Comments:

  It was asked what the difference between billed and cost is.

  We get billed for services through the dental provider. We pay based on set fee schedule based on our relative value for dentist instead of off of billed charges. In the aggregate based on the information we receive, we pay approximately between 60-65% for children's services and 55-60% for adult services of the providers billed charges.

  It was asked what the difference is between what is billed and what is paid

We don't know the difference. We have heard that a dentist's cost is approximately 70% of their billed charges.

- **Deering Clinic Presentation**
  Paula Block – Montana Primary Care Association:

  Paula gave a brief history of the Community Dental Practice (CDP) and the services provided. She stated that currently the staff consists of two dentists, one dental hygienist, four dental assistants, and one administrative/non-clerical staff.

  Paula gave a financial overview of expenses and revenue of the clinic. She stated that this structure works for two major implications: professional liability coverage through Federal Tort Claims Act and section 330 grant provides a back-up source of funding for low income people allows them to see patients on a sliding scale fee. The Deering clinic has worked with local dentists to serve as volunteers and to accept referrals from them. They offer experiences to dental students to work in a health center based clinic and are looking to develop a dental residency program at some future point. She stated that there is a mobile dental service van operated by St. Vincent Healthcare out of Billings.

  Paula stated that there are still some remaining challenges. Demand for dental services for Medicaid clients still far outstrips capacity and low Medicaid rates make it unattractive and financially infeasible for private dentist to accept many Medicaid patients.

  Paula stated that there is some progress in the Deering CHC. She stated that in 2005 they repeated a non-scientific, self-report survey of its health center patients regarding dental care. Four areas were addressed and those were: need of dental care, dental insurance, difficulty getting an appointment, and had their teeth cleaned in the past year.

  Paula stated that there is a consortium in Billings called the Alliance which consists of YCCHD, Billings Clinic, and St. Vincent Healthcare. They are committed to finding community solutions to community problems. They have made the need for more dental services for low income people is a high priority. The alliance is seeking a community analysis to determine how many people are presenting at the Hospital ER with primary dental needs and the capacity for serving Medicaid clients by means of a dentist-by-dentist telephone survey.

  Paula stated that despite the fact that Billings has a CHC based dental program, there are significant unmet dental needs for low income people. The major impediment seems to be low Medicaid payment rates which forces dentist to limit the number of Medicaid beneficiaries they will treat.

  The Deering Clinic Presentation is provided with these minutes.

Questions and Comments:

It was asked that if there was a significant increase in the rates paid would there still be a gap of people that wouldn't get service.

Paula stated that is not a question that either she or the Deering Clinic can really answer that.

It was stated that the issue of dental rates has been before the legislature for at least three biennia and two biennia ago there was a substantial rate increase given. At that time the testimony was not just rates but paperwork and no shows.

- **Montana Dental Association**
  Mary McCue – Montana Dental Association Executive Director:

Mary stated that the discussion of raising rates and the possibility of insuring increased access has been going on for several years. She stated that there was one thing that she wanted people to consider in that when it is said dentists are not serving the Medicaid population we are spending every dollar that the legislature appropriates every biennium on dental services.

Mary stated that certainly the rate is a barrier but is not the only one. Another issue that is significant is the no show rate. A dentist cannot over schedule patients. She stated that approximately five years ago the MDA did a survey of their members with about ninety percent responding. At that point the dentist had said that at least 25% of the Medicaid population doesn't keep their appointments and 8% percent of the non-Medicaid population.

In addition to the issue of rates access is also going to be significantly affected by the number of dentists that we have. Mary went over a graph that she handed out showing the ages of active MDA members. She stated 25% of them are 60 and older and 59 % are age 50 and older which creates a concern. She stated that we do have new dentists coming to Montana and are settling in the bigger cities. One concern is to focus on the rural areas.

Mary went over a handout that MDA got from Laurie Tobol, administrator of the WHICHE and WWAMI programs. This handout illustrates the amount of money that Montana is currently spending per year on dental education. It compares the cost of dental school to medical school and veterinary school.

There was a handout given to show what the MDA plans to do to insure that there will be a sufficient number of dentists in the State of Montana in the next ten to twenty years. Mary stated that they have been talking with the University of Washington for the last couple years about the establishment of a WWAMI type program for dental students. She gave an overview of what that program would do. She stated that they are convinced the only way to get dentist into the eastern

part of the state is for them to spend a significant periods of time in those smaller communities so that they can understand what it means to live and practice there.

Questions and Comments:

An idea was brought up to recruit people from the eastern part of Montana.

A member asked how do you keep these people in Montana long enough to have them repay what Montana paid.

> The board has had the discussion of making it a requirement that these students repay this amount but at this point we are not convinced that the stick approach is the most effective. It is not a requirement in the WWAMI medical students so it would not be fair to single out the dental students.

Another approach was suggested of offering a stipend to go out east and have them sign up for three years.

> When they talked to the U of W this was brought up. One of the things that were said is that if we start with a student that grew up in that area there will be some weight given to students who are more likely to return to those areas.

A member asked how much is Medicaid or patient going to pay.

> Nationally the cost of providing care is 65-70% of charge is the cost of doing business.

What is the Medicaid reimbursement rate right now?

> Duane stated that basically all we have is billed charges. Most providers bill us using their usual customary. A set fee schedule amount not a percentage of billed charges.
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> Mary stated that dentists are urged to send in the actual billed charges so that when the rates are set it is based on the actual amount.

It was asked if the data has been looked at as to what percentages of claims that are paid are billed at the rate paid.

> Duane stated that it was looked at approximately two or three years ago. It was about 85% of the dentist that bill us their amount higher then our billed amount. Roughly 10-15% bills our amount of reimbursement.

It was brought up that if there is a system by which the students will stay in the state it will be better in the legislature.

A member had mentioned getting transportation systems to help with no shows. It was mentioned that an employee of the OPCA is already working with the MDT to get something going.

It was asked what the typical debt burden of someone that graduates from dental school. The average is around $150-160,000.

It was asked if there are other examples of the Deering Clinic where there is a dental clinic associated with the public health department. Those kinds of clinics are in Helena, Missoula, Bozeman, Livingston, Great Falls, etc as well as applications in other communities to bring clinics there.

It was asked if there were any facilities on the reservations or in their health services. There are dentist on those reservations but are not members of the MDA.

It was stated that some dentists that do a circuit where they go to a smaller town about every two weeks or one day every month.

Public Comment:

It was stated that there are several providers in the eastern part of the state. What is happening in eastern Montana is that the children's mental health bureau along with MCI and the communities are working very hard to pull their kids management authority and developing multi-agency efforts in the communities.

Payer mix was brought up. It was stated that some providers have a very limited payer mix and others have a very broad payer mix. If something happens to the Medicaid rate then those with a very limited payer mix will have a higher chance of the operation becoming very disabled.

Draft Format of Rates Grid:
Jeffrey Harrison – OPCA Financial Specialist Supervisor:

Jeff gave a basic overview of the Rate Methodology grid. Some suggestions were made as to what could be added or changed to make it easier to read and not as complex. Some of the suggestions where to give examples, divide it into two chunks and pick a threshold on the number of rates, focus more on the provider types with smaller number of rates and that are more dependent on Medicaid, group together like services as much as possible, and include what the rates are.

It was stated that the reason the rates where not included yet was because if we try to put the rates in for all of the services it would be to large so we waited to get some direction from the commission.

History of Physician Rates:
Mary Dalton – Administrator DPHHS Health Resources Division:

Mary stated that there are different methodologies that the department uses. The most scientific of those are RBRVS, DRG, RVD, and cost for CAHs. Those are actually done

in big studies that look at what the cost of providing that service is. She stated that the only services that are being settled back to cost are hospital and CAH services.

Mary stated that prior to 1997 physicians where paid based on a fee schedule. That schedule was set whenever your fee came about. Fees were set at 65.2% of charges. The only time those charges moved is when the legislature gave an appropriation to increase physician fees. If a new procedure was developed it would start out at that 65.2% of charges.

Denise Brunett – DPHHS Health Resources Division:

Denise went over the slide handout she provided and gave some examples of the conversion factors. She stated that the commission should read the other handout at their leisure. She gave a brief overview of what the document is. It is a document drafted by the fiscal contractor. It is an annual document for when the RBRVS rate update is done every July 1st. It explains every component of RBRVS. The commission was directed to the last page which is the first page of the top two hundred services from Montana Medicaid that account for about 80% of the allotted $50,000,000.

Questions and Comments:

It was asked what happens when the money has been expended but still has part of the year left. Mary stated that if it is this biennium the governor's office has decided the Department will ask for appropriation from the legislature. In other years the Department has done across the board cuts.

Wrap up:
Potential future meeting items:

- Look at grid again
- More people similar to Deering Clinic except from physicians stand point of where community clinics play a part in assisting with access to that kind of care
- Have a philosophical discussion as far as where the commission is headed, and guiding principles

Meeting was adjourned at 4:09 PM

Handouts:
Medicaid Dental Program Reimbursement Information
Actively Practicing MDA Members Graph
Subsidized Dental, Medical, and Veterinary Student Programs
Addressing the Dental Workforce in Montana
Rates Methodology Grid
Medicaid Physician Program Slides
ACS RBRVS and Anesthesia Fee Schedule for FY 06

Attached:

Deering Clinic Presentation

Presentation on Deering Clinic Health Center Dental Services to the DPHHS Rates Commission, 5/16/06,

presentation by Paula Block of Montana Primary Care Association and given for John Felton, Chief Operating Officer of the Yellowstone City-County Health Department

History: The Community Dental Practice (CDP) was a private freestanding dental practice that rented space from YCCHD until 2002. At that time, YCCHD purchased the practice and employed the staff directly. CDP was added to the scope of the Deering Community Health Center in 2003. As such, it is governed by the DCHC Board of Directors, a community board with a majority composed of health center users, as required by the federal grant that supports CHCs. The current staff is composed of two dentists, one dental hygienist, four dental assistants, and one administrative / non-clinical staff.

Services Provided: The CDP is a full-service general dental practice, with the exception of fitting dentures (braces also not provided).

Financial Overview: CDP has an annual operating budget of approximately $767,000. Of that amount, approximately 65% is spent for wages and benefits. Other major categories of expenditures include supplies (about 10%) and facility expenses including depreciation (also approximately 10%). Through nine months of the current fiscal year, CDP has posted an operating margin of just 3%. It is noted that as a CHC-based practice, CDP provides sliding fee scale discounts to any person who has a household income of less than 200% of the federal poverty level.

Revenue Sources: Through ten months of the current fiscal year (ending 4/30/06) 6,153 patients were seen, an annualized total of approximately 7,383. 1,428 dental encounters (23%) were with Medicaid beneficiaries; this equates to an annualized total of approximately 1,713 Medicaid encounters, or an average of approximately 7 Medicaid patients seen per work day out of 29 appointments. Medicaid accounts for 20% of CDP's net patient service revenue, compared to 31% from private insurance, 29% from private (patient personal responsibility) pay, with the remaining 20% accounted for by the federal health center grant. On average, the write-off for Medicaid is 32%, compared to 12% for private insurance and 31% for private pay. The average net revenue per visit is $81.89 for Medicaid, compared to $115.27 for private insurance and $70.64 for private pay (please note that the federal grant subsidizes low income private pay patients through the sliding fee schedule).

Why this structure works: The CDP is financially viable because it is part of the community health center, which has two major implications. 1) Professional liability coverage is provided through FTCA so we do not pay for it. 2) The section 330 grant provides a back-up source of funding for low income people.

Other efforts to increase access to dental services: CDP has worked with local dentists to serve as volunteer dentists and to accept referrals from us. Offering experiences to dental students to work in CHC-based dental clinic and also looking to develop a dental residency program at some point. Billings also has a mobile dental services van operated by St. Vincent Healthcare.

Remaining challenges: Demand for dental services for Medicaid beneficiaries still far outstrips capacity. Low Medicaid rates make it unattractive or financially infeasible for private dental practices to serve very many Medicaid patients. It would help if Medicaid maintained a list of all Medicaid dental providers to respond to patient inquiries. The Medicaid dental referral line tells callers to contact CDP, which is deemed to be a referral, although we do not believe that this action meets the intent of "providing a referral". Every day the CDP receives 15-20 inquiries per day for Medicaid services that we cannot provide even with our higher levels of Medicaid service and the section 330 federal grant.

Progress in Deering CHC: In 2005 DCHC repeated a non-scientific, self-report 2000 survey of its health center patients regarding dental care. The four areas addressed were: 1) in need of dental care now (84% in 2000, 80% in 2005); 2) have dental insurance including Medicaid (10% in 2000, 33% in 2005); 3) had difficulty getting a dental appointment (72% in 2000, 52% in 2005); and, 4) had teeth cleaned in past year (12% in 2000, 18% in 2005).

Community initiatives: The Alliance, a consortium of YCCHD, Billings Clinic and St. Vincent Healthcare, is committed to "finding community solutions to community problems". The need for more dental services for low income people is a high priority. A 2005 of Deering CHC patients indicated that even with the availability of an on-site dental clinic that serves a low income population, 62% had not seen a dentist in over a year, and the most common reasons for lack of care were identified by these consumers as lack of money and lack of dentists accepting time payment s for services. The Alliance is undertaking a community analysis to determine: 1) how many people are presenting at the hospital emergency departments with primary dental needs: and, 2) the capacity for serving Medicaid beneficiaries by means of a dentist-by-dentist telephone survey that will ask if dentists accept Medicaid patient, how many Medicaid patients the practice will accept, and if the practice is accepting new Medicaid patients.

Bottom line: Despite the fact that Billings has a CHC-based dental program, there are significant unmet dental needs for low income people. The major impediment seems to be low Medicaid payment rates which forces dentist to limit the number of Medicaid beneficiaries they will treat.